FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED B. WING IL6011597 05/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2081 NORTH MAIN STREET **LOFTREHAB & NURSING OF CANTON CANTON, IL 61520** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 Initial Comments S 000 Complaint Investigation: 2224180\IL147390 S9999 Final Observations S9999 Statement of Licensure Violations: 300.690b) 300.690c) Section 300.690 Incidents and Accidents b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695. notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the Affachment A occurrence. Statement of Licensure Violations This requirement is not met as evidenced by:

nois Department of Public Health

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY,	STATE, ZIP CODE	1 001	05/28/2022		
LOFTREHAB & NURSING OF CANTON 2081 NORTH MAIN STREET CANTON, IL 61520								
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S9999	Continued From page 1		S9999					
	failed to notify the S	and record review, the facility tate Agency of an injury for its (R1) reviewed for injuries	<i>1</i> //2					
	Findings include:					i.		
	documents, "(R1) he room. This nurse ob between recliner and bleeding and cut. Eaplece of skin. (R1) s treatment. Will continue R1's Progress Note documents, "(R1) re room): NO (new ord (milligrams) po (by making the condition of wound. It black and gangrenous supply reforming. If s gangrenous make approximate of the condition of wounds.	dated 5/11/22 at 8:28 PM, turned from ER (Emergency er) for Ceftin 500 mg nouth) BID (two times a day) e dressing daily and check High probability of becoming us d/t (due to) lack of blood s/s (signs and symptoms) of pointment with ENT (Ear, ctor for removal. PCP						
	documents R1 was a 5/11/22 at 5:16 PM. I reaching for a remote striking his right ear ocaused an avulsion lawhich is hanging on I Progress Note dated documents, "Procedu Cleansed with saline avulsion of the right e	dated 5/12/22 at 7:05 AM, admitted to the hospital on nitial comments: "(R1) was a and fell out of his chair on the railing of the bed. This accration of his right earlobe by a thread." Hospital 5/11/22 at 5:57 PM, are right earlobe avulsion. 1.5 x 0.5 cm (centimeter) parlobe. Dermabond two eattach the earlobe. Benzoin						

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C B. WING IL6011597 05/28/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2081 NORTH MAIN STREET** LOFT REHAB & NURSING OF CANTON CANTON, IL 61520 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 and half inch steri -strips were also used to secure the lobe to the ear. There was still some oozing and this was covered anteriorly and posteriorly with surgical and a sterile gauze dressing. (R1) is advised of the high likelihood of necrosis due to lack of blood supply into this completely avulsed segment. As the tissue becomes black and necrotic (R1) ought to follow up with the ear nose and throat physician for removal." R1's Wound Report dated 5/18/22, documents the wound is 2 cm x 1 cm x Not Measurable cm .R1 had a fall and suffered avulsion laceration to his right earlobe. Emergency department Physician applied Dermabond and steri strips with benzoin to try to reattach the lobe but was expecting the lobe would likely necrosis from lack of blood flow as it was only attached by a thread. This involves about half of the earlobe. The evolved portion was dark purple nearly black and is likely going to be non-viable. R1's Wound Report dated 5/25/22, documents the wound is 2 x 1 x Not Measurable cm. The evolved portion of earlobe is black and completely necrosed today and was debrided, R1 will have deformity to this area of his earlobe. On 5/27/22 at 12:20 PM, V2 (Assistant Director of Nursing) stated, "I was told that (R1) had a laceration on his ear so I told (V3/Registered Nurse) to send (R1) to ER (Emergency Room) to see if he needed stitches. (R1) did not need stitches, they used glue to hold the area together. We (the facility) send a report to (State agency) anytime a resident gets sutures, staples, or an injury of unknown origin. Also, any accident that results in a hospital stay or a resident chocking. We did not send a report to (State agency) for

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SOURCE PROVIDER SUPPLIER ILBOITSON NUMBER ILBOITSON NUMBER ILBOITSON NUMBER ILBOITSON NUMBER ILBOITSON NUMBER STREET ADDRESS. CITY. STATE, ZIP CODE 2081 NORTH MAIN STREET CANTON, IL 01520 PREFX TAG SUBMARY STATEMENT OF DEPTICENHEES D PROVIDERS PLAN OF CORRECTION CHARLES PLAN OF C	Illinois Department of Public Health			2 n = 22			FORM APPROVED	
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